DENTAL REGISTRATION AND HISTORY

INSURANCE IS FILED AS A COURTESY TO YOU. YOU WILL BE BILLED AFTER 30 DAYS.

1. PATIENT INFORMATION

Date ____________

Patient ________________________________

Address ________________________________

____

City State Zip

Sex __ M __ F Age ____ Birthdate ______________

___ Single ___ Married

Patient SS# ________________________________

Occupation ________________________________

Employer ________________________________

Employer Address ________________________________

____

Spouse's Name ________________________________

Birthdate ____________ SS# ________________

Spouse's Employer ________________________________

Whom may we thank for referring you?

____

2. FINANCIAL RESPONSIBILITY

Name of the individual responsible for this account:

____

Do you have dental insurance? ___ Yes ___ No

If yes, please complete the following assignment and release.

ASSIGNMENT RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ________________________ and assign directly to Dr. ________________________ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

____

Responsible Party Date

3. TELEPHONE NUMBERS

Home ________________ Work ________________

E-mail address: ________________________________

Spouse's Work ________________________________

Physician's Name ________________________________

Physicians Telephone Number ________________________________

Name/Location of Pharmacy ________________________________

Pharmacy Telephone Number ________________________________

Emergency Contact:

Name ________________ Tel # ________________

Cell # ________________ Work # ________________

4. DENTAL HISTORY

Reason for today's visit ________________________________

____

Former Dentist ________________________________

City/State ________________________________

Date of last dental visit ________________________________

Date of last dental x-ray ________________________________

Was all treatment completed? ___ Yes ___ No

Bad Breath ___ Yes ___ No

Bleeding Gums ___ Yes ___ No

Blisters on lips or mouth ___ Yes ___ No

Burning sensation on tongue ___ Yes ___ No

Chew on one side of mouth ___ Yes ___ No

Cigarette, pipe or cigar smoking ___ Yes ___ No

Clicking or popping jaw ___ Yes ___ No

Dry Mouth ___ Yes ___ No

Fingernail biting ___ Yes ___ No

Food collection between teeth ___ Yes ___ No

Foreign objects ___ Yes ___ No

Grinding teeth ___ Yes ___ No

Gums swollen or tender ___ Yes ___ No

Jaw pain or tiredness ___ Yes ___ No

Lip or cheek biting ___ Yes ___ No

Loose teeth or broken fillings ___ Yes ___ No

Mouth breathing ___ Yes ___ No

Mouth pain, brushing ___ Yes ___ No

Orthodontic treatment ___ Yes ___ No

Sensitivity to cold ___ Yes ___ No

Sensitivity to heat ___ Yes ___ No

Sensitivity to sweets ___ Yes ___ No

Sensitivity when biting ___ Yes ___ No

Sores or growths in mouth ___ Yes ___ No

How often do you floss? ________________

How often do you brush? ________________

5. ALLERGIES

___ Aspirin

___ Barbiturates (sleeping days)

___ Codeine

___ Iodine

___ Latex

___ Local Anesthetic

___ Penicillin

___ Sulfa

___ Other

____

____

6. HEALTH HISTORY

AIDS	___ Yes	___ No	Epilepsy	___ Yes	___ No	Respiratory Disease	___ Yes	___ No
Anemia	___ Yes	___ No	Fainting	___ Yes	___ No	Rheumatic Fever	___ Yes	___ No
Arthritis, Rheumatism	___ Yes	___ No	Dizziness	___ Yes	___ No	Scarlet Fever	___ Yes	___ No
Artificial Heart Valves	___ Yes	___ No	Glaucoma	___ Yes	___ No	Shortness of breath	___ Yes	___ No
Artificial Joints	___ Yes	___ No	Headaches	___ Yes	___ No	Sinus Trouble	___ Yes	___ No
Asthma	___ Yes	___ No	Heart Murmur	___ Yes	___ No	Skin Rash	___ Yes	___ No
Back Problems	___ Yes	___ No	Heart Problems	___ Yes	___ No	Special Diet	___ Yes	___ No
Bleeding abnormally with	___ Yes	___ No	Pacemaker	___ Yes	___ No	Stroke	___ Yes	___ No
extractions or surgery			Mitral Valve Prolapse	___ Yes	___ No	Swelling of Feet or Ankle	___ Yes	___ No
Blood Disease	___ Yes	___ No	Hepatitis	___ Yes	___ No	Swollen Neck Glands	___ Yes	___ No
Cancer	___ Yes	___ No	type ___________			Thyroid Problems	___ Yes	___ No
type ___________			Herpes	___ Yes	___ No	Tonsilitis	___ Yes	___ No
date ___________			High Blood Pressure	___ Yes	___ No	Tuberculosis	___ Yes	___ No
Chemical Dependency	___ Yes	___ No	HIV Positive	___ Yes	___ No	Tumor or growth on	___ Yes	___ No
Chemotherapy	___ Yes	___ No	Jaundice	___ Yes	___ No	head or neck		
Circulatory Problems	___ Yes	___ No	Jaw Pain	___ Yes	___ No	Ulcer	___ Yes	___ No
Congenital Heart Problems	___ Yes	___ No	Kidney Disease	___ Yes	___ No	Veneral Disease	___ Yes	___ No
Cortisone Treatments	___ Yes	___ No	Liver Disease	___ Yes	___ No	Weight Loss, unexplained	___ Yes	___ No
Cough, persistent/bloody	___ Yes	___ No	Low Blood Pressure	___ Yes	___ No	Women:	___ Yes	___ No
Diabetes	___ Yes	___ No	Nervous Problems	___ Yes	___ No	are you pregnant?	___ Yes	___ No
Emphysema	___ Yes	___ No	Psychiatric Care	___ Yes	___ No	Due date _________		
Contact lenses?	___ Yes	___ No	Radiation Treatment	___ Yes	___ No	Are you nursing?	___ Yes	___ No

List major hospitalizations or operations ____

7. MEDICATIONS CURRENTLY TAKING

8. UPDATES (to be completed at future appointments)